

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10083

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10089

Reg. Dist. No. 257

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Q.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Queen Anne</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Queen Anne</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Willoughby</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>William</u> (Middle) <u>Alexander</u> (Last) <u>Butler</u>		(Month) <u>Oct.</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 24 1880</u>
9. AGE last birthday <u>75</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
13. FATHER'S NAME <u>ROBERT Alexander Butler</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Bertha Butler - Queen Anne, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary Thrombosis</u>		<u>3 yrs.</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Cardiovascular Disease</u>		<u>3 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1955, to Sept., 1955, that I last saw the deceased alive on Sept. 30, 1955, and that death occurred at 10:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Oct. 10, 1955</u>	<u>Seabrook</u>	<u>Queen Anne, Md.</u>	<u>10/7/55</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>10/8/55</u>	<u>H. H. Norris</u> <u>Elaine Armstrong</u>	<u>St. Michael's</u>	<u>Easton, Md.</u>	

BUREAU V. S.

OCT 20 1955

RECEIVED

10084

CERTIFICATE OF DEATH

Reg. Dist. No. 252...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <u>Centreville</u>				X <u>Centreville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>LIZZIE</u> <u>COKER</u>				<u>Oct</u> <u>3</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>7</u>	<u>Caucasian</u>	<u>Widowed</u>	<u>May 21 - 1878</u>	<u>77</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>Domestic</u>		<u>Queen Anne's Co. Md</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Oliver Hard</u>				<u>Alphonsa Hutchins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS:			
<u>Yes</u> <u>WW</u>				<u>Josephine Coker Centreville Md</u>			
15. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1998 IMMEDIATE CAUSE (A) <u>Cancer of stomach & bladder</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>0</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from <u>Jan 1 - 1955</u> , to <u>Oct 3 - 1955</u> , that I last saw the deceased alive on <u>Oct 3 - 1955</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. Henry Fisher</u>				DATE SIGNED <u>10/5-55</u>			
M.D. <u>Centreville Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct 5 - 1955</u>		<u>Christfield</u>		<u>Centreville Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10-5-1955</u>		<u>Oliver Armstrong</u>		<u>Barton Bros. Centreville Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 7 1955

BUREAU V. S.

Handwritten signature or name

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **10085**
CERTIFICATE OF DEATH

10091

Reg. Dist. No. **251**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>Ind.</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Church Hill</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Church Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WILLIAM A. COURSEY</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 5 1955</u>			
5. SEX: <u>m.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Aug. 21-1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired): <u>Carpenter Building</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Samuel C. Coursey</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Edenfield</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-019-455</u>		17. INFORMANT'S ADDRESS: <u>Frederick Coursey Church Hill Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 5</u> , 19 <u>55</u> , to <u>Oct 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 5</u> , 19 <u>55</u> , and that death occurred at <u>6:50</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>W. Henry Frasier</u>		ADDRESS <u>M. D. Centerville Ind</u>		DATE SIGNED <u>10/6-55</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 7</u>		NAME OF CEMETERY OR CREMATORY <u>Sudlersville</u>		LOCATION (City, town, or county) (State) <u>Shedlersville Ind.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-7</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>		24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill Ind.</u>	

BUREAU V. S.

OCT 10 1953

RECEIVED

10086

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10092

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 253...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Queen Anne</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Centerville</u>	LENGTH OF STAY (in this place) <u>all her life</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Centerville</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <u>Sorothy Emory Phillips</u> (Middle) <u>Earle</u> (Last)		(Month) <u>Oct</u> (Day) <u>30</u> (Year) <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>May 19-1890</u>
9. AGE last birthday: <u>65</u> yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Home near Centerville md</u>	
11. BIRTHPLACE (State or foreign country): <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Wm C Emory</u>		14. MOTHER'S MAIDEN NAME: <u>Cora Frances Massey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>220-34-9393</u>	
17. INFORMANT & ADDRESS: <u>Mrs Sorathy Massey - Massey md</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) <u>Found dead in bed</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>W. Henry Fisher</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11/3-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Nov. 4 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Christfield Cemetery</u>		LOCATION (City, town, or county) (State) <u>Centerville, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>11-4-55</u>		REGISTRAR'S SIGNATURE <u>Oliver Armstrong</u>	
24. FUNERAL DIRECTOR <u>Barton Bros. Centerville, Maryland</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

BUREAU V. S.

NOV 7 1955

RECEIVED

10087

10093

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 253

1. PLACE OF DEATH: COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>near Stevensville</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>near Stevensville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED: (Type or Print) (First) <u>Wm</u> (Middle) <u>Green</u> (Last) <u>Green</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 27</u> 19 <u>55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>Ch</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>1887</u>
9. AGE, last birthday: <u>68</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>near Stevensville md</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>? Green</u>		14. MOTHER'S MAIDEN NAME: <u>Dont know</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>35 Titus Rd. Glen Cove L.I.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) <u>This man has complained of heart trouble</u> DISEASES OR CONDITIONS, IF ANY, giving rise to the above cause DUE TO stating underlying cause last (c) <u>for last 10 yrs</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>W. Henry Fisher - Centerville md</u>		DATE SIGNED <u>10/29-55</u>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		24. FUNERAL DIRECTOR ADDRESS
DATE REC'D BY LOCAL REG. <u>Oct 30-55</u>	REGISTRAR'S SIGNATURE <u>Elizabeth Hyster</u>	<u>Barton Bros Centerville Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 3 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10088

2411 N. Charles Street, Baltimore

10094

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Queen Anne's</u> <u>Robert</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Q. A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Rachel</u> (First) <u>Emily</u> (Middle) <u>Hazelton</u> (Last)		4. DATE OF DEATH <u>Oct.</u> (Month) <u>7</u> (Day) <u>1955</u> (Year)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, (MARRIED), WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 19, 1891</u>
9. AGE last birthday <u>64</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jerry Hazelton</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Richardson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>Eliza Derry - Chester, Md</u>	
17. INFORMANT AND ADDRESS <u>Eliza Derry - Chester, Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>Sev. Yrs</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary Thrombosis</u> Antecedent cause(s) (b) <u>Angina Pectoris</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April, 1953, to Oct, 1955, that I last saw the deceased alive on Oct. 3, 1955, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

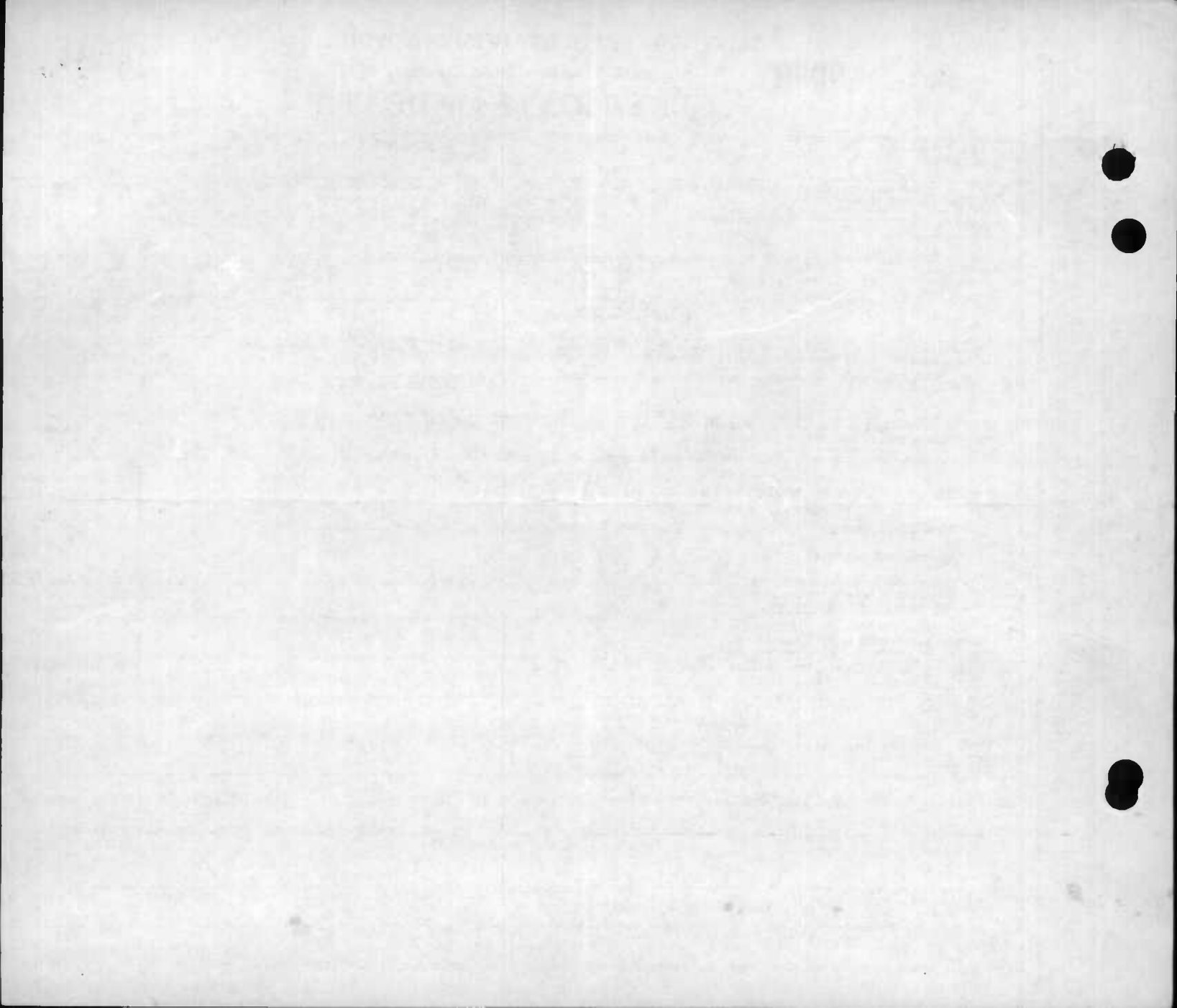
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>10-7-55</u>	NAME OF CEMETERY OR CREMATORY <u>Union Cem</u>	LOCATION (City, town, or county) <u>Chester</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>10-5-55</u>		REGISTRAR'S SIGNATURE <u>J. B. Johnson</u>		24. FUNERAL DIRECTOR <u>J. B. Johnson</u>	
				ADDRESS <u>Annapolis</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

10089

2411 N. Charles Street, Baltimore

10095

CERTIFICATE OF DEATH

Reg. Dist. No. 253

Item 2, Film 188 10-27-55 et

1. PLACE OF DEATH- COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>St. Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) *****	
3. NAME OF DECEASED (First) <u>Mary</u> (Middle) <u>Thomas</u> (Last) <u>Thomas</u>		4. DATE OF DEATH (Month) <u>Oct</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED, WIDOWED <input checked="" type="checkbox"/> DIVORCED, <u>(Specify)</u>	8. DATE OF BIRTH <u>Oct 13-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>81</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Julius</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Thrombosis + hemiplegia

INTERVAL BETWEEN ONSET AND DEATH

Oct 5, 1955

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterio-sclerosis, hypertensive cardio-vascular disease

3 years

(c) mitral regurgitation with decompensation

6 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 10, 1955, to Oct 17, 1955, that I last saw the deceased alive on Oct 17, 1955, and that death occurred at 2:20 p. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Theodor Sattelmair M.D.StevensvilleOct. 18, 1955

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Final</u>	<u>Oct 19-55</u>	<u>Stevensville</u>	<u>Stevensville</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Oct 19, 55</u>	<u>Elizabeth Norton</u>	<u>Edgar L. Lane</u>	<u>Chesapeake</u>	

RECEIVED
OCT 24 1955
BUREAU V. S.

10090

CERTIFICATE OF DEATH

Reg. Dist. No. 251.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Millington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>HARRY</u> <u>WALLACE</u>				<u>Oct.</u> <u>12</u> <u>1933</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Jan. 13, 1881</u>	<u>74</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Farm</u>		<u>Del.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Wallace</u>				<u>Hervietta Sylvester</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>no</u>				<u>Mrs. Lula Wallace-Millington Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>apoplexy</u>							<u>3 days</u>
ANTECEDENT CAUSE (S) DUE TO <u>Arrhythmia fibrillation</u>							<u>3 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized Arteriosclerosis</u>							<u>10 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>none</u>		<u>none</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
<u>none</u>		<u>none</u>		<u>none</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<u>none</u>		<u>none</u>		<u>none</u>			
22. I hereby certify that I attended the deceased from <u>Feb. 5, 1933</u> , to <u>Oct. 12, 1933</u> , that I last saw the deceased alive on <u>Oct. 11, 1933</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. H. Hamilton</u>				ADDRESS <u>Millington</u>		DATE SIGNED <u>Oct. 12/33</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 16, 1933</u>		<u>Millington Cem.</u>		<u>Millington, Kent Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct. 12</u>		<u>Edgar L. Kane</u>		<u>Edward Fellows</u>		<u>Millington, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 27 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **10097**
10091 CERTIFICATE OF DEATH

Reg. Dist. No. **251**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Green Anne	MARYLAND	STATE Ind.	COUNTY G.A.
CITY (If outside corporate limits, write RURAL OR and give nearest town) Rural Centerville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) Rural Centerville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
WESLEY WASHINGTON		Oct. 26 1955	
5. SEX: Male	6. COLOR OR RACE: Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: Jan. 7 - 1892
9. AGE last birthday: 63 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Farm laborer		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY: USA	
13. FATHER'S NAME: James Washington		14. MOTHER'S MAIDEN NAME: Susan Kohn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk. (If Yes, give war or dates service))		16. SOCIAL SECURITY NO.	
17. INFORMANT'S ADDRESS: Mrs. Wm. Washington - Centerville Ind.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
592X IMMEDIATE CAUSE		(A) Chronic Interstitial nephritis	
ANTECEDENT CAUSE (B)		DUE TO with heart complication	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 10, 1955 , to Oct 26, 1955 , that I last saw the deceased alive on 10-25, 1955 , and that death occurred at 11:30 M, from the causes and on the date stated above.			
SIGNATURE: W. J. Henry Fisher		ADDRESS: Centerville Ind. DATE SIGNED: 10/28/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		DATE THEREOF: Oct 29	
NAME OF CEMETERY OR CREMATORY: Chesterfield		LOCATION (City, town, or county) (State): Centerville Ind.	
DATE REC'D BY LOCAL REGISTRAR: 10-28		REGISTRAR'S SIGNATURE: Edgar L. Lane	
24. FUNERAL DIRECTOR: Edgar L. Lane		ADDRESS: Church Hill Ind.	

NOV 2 1955

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10098

10092

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Q.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Centreville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Centreville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		STREET ADDRESS (If rural, give location) <u>Starr</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Mary Elizabeth Wilkens</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 4 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 6, 1882</u>
9. AGE last birthday <u>72</u> yrs.		10. Kind of BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Berry</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Emma Stanford - Centreville Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>260X</u> Immediate cause (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> Antecedent cause(s) (b) <u>Diabetes Mellitis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>		<u>Yrs</u> <u>20 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1953 to Sept. 1955, that I last saw the deceased alive on Sept. 26, 1955, and that death occurred at 11:58 m., from the causes and on the date stated above.

SIGNATURE Irvin D. Hoyt MD (Degree or title) ADDRESS Queenstown, Md. 1955 DATE SIGNED 10/5/55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>10/8/55</u>	NAME OF CEMETERY OR CREMATORY <u>New Town Cem.</u>	LOCATION (City, town, or county) (State) <u>Cordova Md.</u>
DATE REC'D BY LOCAL REG. <u>10-6-55</u>	REGISTRAR'S SIGNATURE <u>Elaine Armstrong</u>	24. FUNERAL DIRECTOR <u>James B. Doherty, Canton Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1.5

OCT 18 1965

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